

CLIENT ACKNOWLEDGEMENT FORM

I, _____, understand that I will be treated by
(Name of client)
Dr./Ms./Mr. _____, a service extender for
(Name of service extender)
Dr. _____, as licensed psychologist.
(Name of licensed psychologist)

I understand that the service extender is not a licensed psychologist in Idaho and I may contact
Dr. _____, at any time concerning my treatment.
(Name of licensed psychologist)

I also understand that I will be seen by the licensed psychologist within the first three (3)
meetings with the service extender as required by the Idaho Board of Psychologist Examiners.

Signed this date: _____
(mm/dd/yyyy)

By: _____
(Signature of client)

(Printed name of the client)